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ABSTRACT

The association of family income with child health is well-known. Compared to children from affluent families, low-income children are more likely to suffer from various chronic and sub-acute health problems including dental decay, asthma, earaches, vision deficiencies, and spotty immunizations. These problems interfere with healthy development. One source of these health disparities may be access to health care. Families of poor children often lack both health insurance and money to pay for medical care. Consequently, they traditionally have been unable to schedule routine visits to doctors, dentists, and optometrists and unable to purchase medication and eyeglasses when prescribed. The State of New Jersey has recently begun a new program, called FamilyCare, which offers no- or low-cost insurance to low-income families. This report examines whether the provision of this insurance affects health care access for children in poor families. Researchers interviewed parents who had recently enrolled in the FamilyCare program, investigating how access for their children to health care has changed since acquiring health insurance. Findings demonstrate that the FamilyCare health insurance program dramatically improves access to health care. Parents who are provided with the necessary resource prove to be effective managers of their children's health care. (Contains 13 references.) (SM)

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Does Health Insurance Improve Children's Lives?

A Study of New Jersey's FamilyCare Program

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Executive Summary

The association of family income with child health is well known. In comparison to children from affluent families, low-income children are more likely to suffer a variety of chronic and sub-acute health problems. These include dental decay, asthma, earaches, vision deficiencies, and spotty immunizations. These problems interfere with healthy development.

One source of the health disparities between children from poor and affluent families may be access to healthcare. The families of poor children often lack both health insurance and the money to pay for medical care. Consequently, these families traditionally have been unable to schedule routine visits to doctors', dentists', and optometrists' offices, and have been unable to purchase medication and eyeglasses when these are prescribed.

The State of New Jersey has recently begun a new program, called FamilyCare, which offers no- or low-cost insurance to low-income families. The question we seek to answer in this report is whether the provision of this insurance affects healthcare access for children in poor families. To answer the question, we interviewed parents who had recently enrolled in the FamilyCare program, and asked questions about how access for their children to healthcare has changed since acquiring health insurance.

Our findings demonstrate that the FamilyCare Health Insurance Program dramatically improves access to healthcare. Parents who are provided with the necessary resource—health insurance—prove to be effective managers of their children's healthcare.

Introduction

Children in poor families are more likely to suffer from ill health than are children from affluent families. The disparity between poor and rich children is seen in virtually every measure of well-being. For example, only 68% of children in impoverished families are judged by their mothers to be in excellent health; in comparison, 86% of non-poor children are viewed by their mothers as having excellent health (National Health Survey, 1997). Similarly, The National Center for Health Statistics reports that impoverished children are more likely than other children to have untreated dental caries (cavities), incomplete immunizations, and regular visits to physicians (National Center for Health Statistics, 2001). Because the health problems of poor children are well documented and approach common knowledge, we turn next to the sources of increased susceptibility to poor health in this population.

Poor youth face a host of obstacles in achieving and maintaining health. These include diet and weight [Centers for Disease Control and Prevention, 1995], a higher incidence of weight problems [Andersen, Crespo, Bartlett, Cheskin, and Pratt, 1998]), and lower levels of physical activity and high levels of sedentary pursuits such as watching television (Andersen, et al, 1998). Low income families may live in neighborhoods that expose children to environmental lead [Markowitz, 2000].

Poor youth also lack access to healthcare, and this contributes to poor health. For example, children from affluent families are twice as likely as children from impoverished families to receive regular physicals. Routine physicals provide opportunities for primary care providers to correct problems in their early stages, to complete immunization series, and to offer nutrition and health counseling (Newacheck, 2000).

Because poor families lack health insurance (poor children are twice as likely as affluent children to live in such families) and funds to pay for private medical services, children in poor families are often taken for charity care to emergency rooms that are legally obligated to provide this service. Poor children are 50% more likely than children from affluent families to have been recently treated for an illness or injury in an emergency room (National Center for Health Statistics, 2001). While emergency rooms provide high quality care for certain types of problems, they cannot provide the integrative management of healthcare that is

essential for healthy development in children. For example, immunization records are not maintained by emergency rooms, emergency room personnel have no knowledge of a child and the family, return visits for the monitoring of an illness are not scheduled, to mention just a few of the problems that result from the misuse of emergency rooms as substitutes for primary care providers.

Does the Provision of Health Insurance Improve Access?

Research has established that those with health insurance make more and better use of the healthcare system. Those with health insurance make more visits to the doctor, are less likely to visit emergency rooms, and are more likely to have a single primary care provider who manages the healthcare of an entire family.

Two studies have found that children whose families have health insurance receive better care than children whose families are without insurance. Newacheck, Stoddard, Hughes, and Pearl (1998) found that children without health insurance were six times as likely as insured children to have no usual source of care. For those with a usual source of care, uninsured children were twice as likely as insured children not to have a regular doctor, and uninsured children were more than one and one half times as likely as insured children not to have access to care after normal business hours. Uninsured children in poor health had only a quarter as many contacts with a physician as children who were insured.

Stoddard, St. Peter, and Newacheck (1994) compared the likelihood of seeking medical attention for specific conditions based on insurance status (i.e., children with health insurance compared to children without health insurance). Uninsured children were significantly less likely to receive help for conditions such as pharyngitis, acute earache, recurrent ear infections and asthma.

Neither of the two studies just described demonstrates that providing health insurance directly affects care. It might be argued that families who have health insurance are more conscientious than families who lack health insurance, and it is the difference in parental conscientiousness, not health insurance status, that accounts for differences in accessing healthcare. However, a recent study by Mulvihill, Telfair, Mulvihill, and

Jackson (2000) studied families who had recently received health insurance, and compared the families' accessing of care prior to, and following, the receipt of health insurance coverage. The families in this study were enrolled in Alabama's CHIP program known as ALL Kids, a program similar to the New Jersey FamilyCare Program studied in this research. In the 3,739 Alabama families surveyed, 29% of the children had not had access to health insurance at any time prior to enrollment in the program and 44% of them had stated that cost was the main reason for not having health insurance. For families previously without insurance, enrollment resulted in an increase in children with a consistent source of primary care (i.e. medical home), improved access to dental and vision care, and more frequent purchase of prescribed medications. Following the receipt of health insurance, the percentage of children receiving physicals nearly doubled. The results of this survey demonstrate that the provision of health insurance does improve access to healthcare for children.

Similar results emerge from an evaluation of the Florida Family Care Program, which also resembles the New Jersey FamilyCare Program. According to Shenkman, Steingraber, Bono and Youngblade (2000), 15% of new enrollees in the Florida KidCare Program reported unmet needs for routine care as compared to 1% of those enrolled for 12 months. Shenkman et al conclude that "with the exception of dental care, all Kidcare Program components had statistically significant decreases in reports of unmet need for routine care, specialty care, prescription drugs, mental health care, and surgical procedures, when comparing new enrollees to those followed for 12 months."

Our goal in the research that follows was to determine whether the New Jersey FamilyCare Program is effective in improving access to healthcare for low-income children.

Structure of the New Jersey FamilyCare Program

The state of New Jersey, with the implementation of its version of the CHIP, called the New Jersey FamilyCare Program, has targeted children at or below 350% of the federal poverty level as eligible for subsidized health insurance. This program incorporates an expanded Medicaid program (Plan A), which includes families at or below 133% of the federal poverty level. Plans B and C require family incomes to fall above 133% but at or

below 200% of the federal poverty level. Plan D requires income between 200% and 350% of the federal poverty level.

Based upon Census Bureau data collected in March 1997, the State of New Jersey estimated that 347,000 children were uninsured as of January 1, 1998. One hundred ninety six thousand of these children had had no insurance for at least a year. The State projected that without the expansion of coverage provided by the NJ FamilyCare Program, this number would increase to 368,000, with 208,000 uninsured for at least a year. It was estimated that of the 368,000, 119,000 would be eligible for Medicaid, 41,000 for Plan A (expanded Medicaid), 52,000 for plans B and C and 62,000 for plan D (National Academy for State Health Policy, Feb. 98 – Sept. 99). Allowing for rollback (some plans require not having had insurance within the last six months) the total number of children eligible for Medicaid and New Jersey FamilyCare is 274,000 statewide with 161,610 eligible for FamilyCare alone. As of March 30, 2001, 76,043 children have been enrolled in the FamilyCare program statewide. According to the State, the target population in 1998, for Camden County was 7,386. As of March 7, 2001, 5,640 (76%) children in the County had been enrolled into the FamilyCare Program.

Evaluation of New Jersey FamilyCare's Effect on Health Care Access in Children

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To assess the effects of the provision of health insurance on healthcare access for children, we followed the strategy used in Alabama and Florida (this research was reviewed in a previous section). Parents recently enrolled in the New Jersey FamilyCare Program were contacted and asked to report on their healthcare practices prior to, and since, receiving health insurance. We asked parents questions concerning preventive health services such as immunizations and routine health, dental, and vision checkups. Parents were also asked questions about acute health care issues, the purchase of prescription medications, and the typical sources of healthcare services. The goal was to determine whether any changes in healthcare practices in these different areas had changed as a result of receiving healthcare insurance.

Participants

All families enrolled in the FamilyCare Program for one year or less residing in Camden County, New Jersey (619 total families) were sent letters inviting participation in our study. Fifty-seven families of these families were interviewed.[1]

Method

The mother in each family was interviewed over the phone about preventative and acute healthcare practices. Mothers were asked what their practice was before enrollment in health insurance and what their practice was since receiving coverage through New Jersey FamilyCare. The interviews were audio-recorded, transcribed, and then coded. In this report we focus on the twelve indicators of healthcare access that are presented below. For each indicator, we asked mothers to describe the situation a) prior to obtaining health insurance, and b) since enrolling in FamilyCare.

Medical Home

1) Does the child have a primary care provider?

Preventive Care

2) Has the child received a routine physical?
3) Has the child been tested for exposure to lead?
4) Are the child's Immunizations up to date?
5) Has the child received a routine dental checkup and teeth cleaning?
6) Has the child had a vision test?

Acute Care

7) When the child is ill, is he/she taken immediately for treatment, or is there a delay in the hopes that the problem will disappear?

[1] We could interview only a modest number of families due to limited funds. Moreover, only families able to speak English or Spanish were interviewed, as these are the languages available to the researchers. Many of our letters were returned with notification that the addressee no longer lived at the address, many families did not respond at all to our letter, and interviews could not be arranged with some families that had expressed a willingness to participate.

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8) When a child is ill, do you take him/her to the emergency room, a clinic, or to a doctor's office?

Medical Expenses as a Barrier to Healthcare

9) Has the cost of eyeglasses prevented the purchase of them for a child?
10) Has the cost of medication prevented the purchase of medication prescribed for the child?
11) Has the lack of funds prohibited you from obtaining a referral to a specialist for your child?
12) Are you anxious about your ability to pay for needed healthcare for your children?

Results

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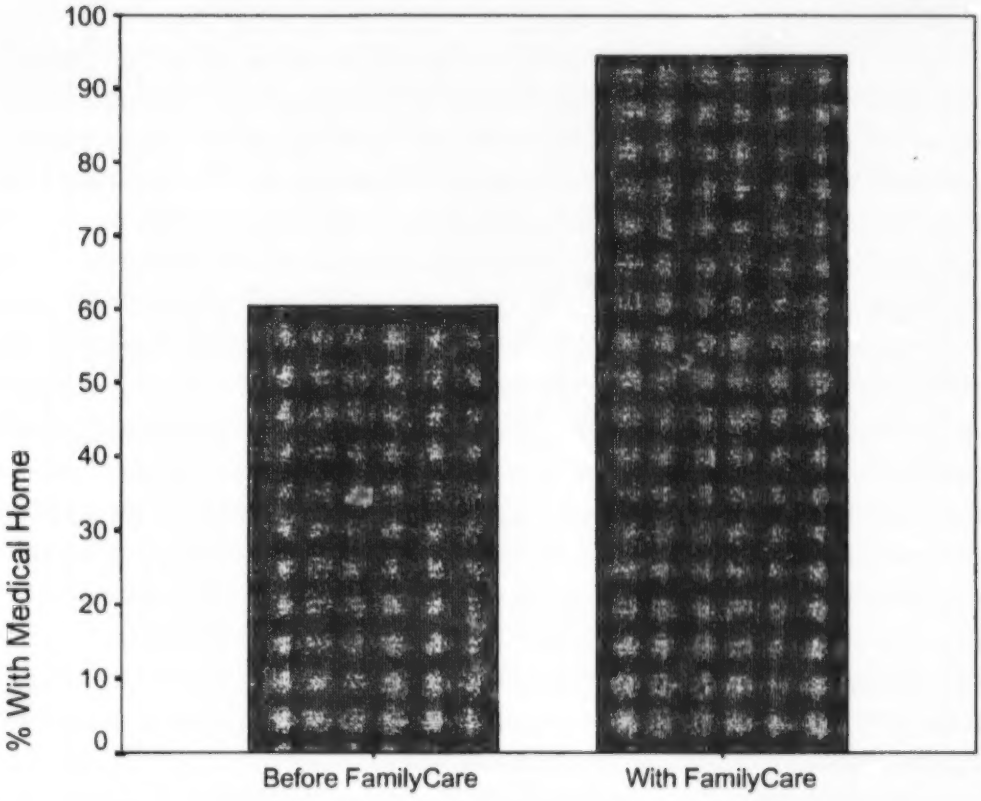
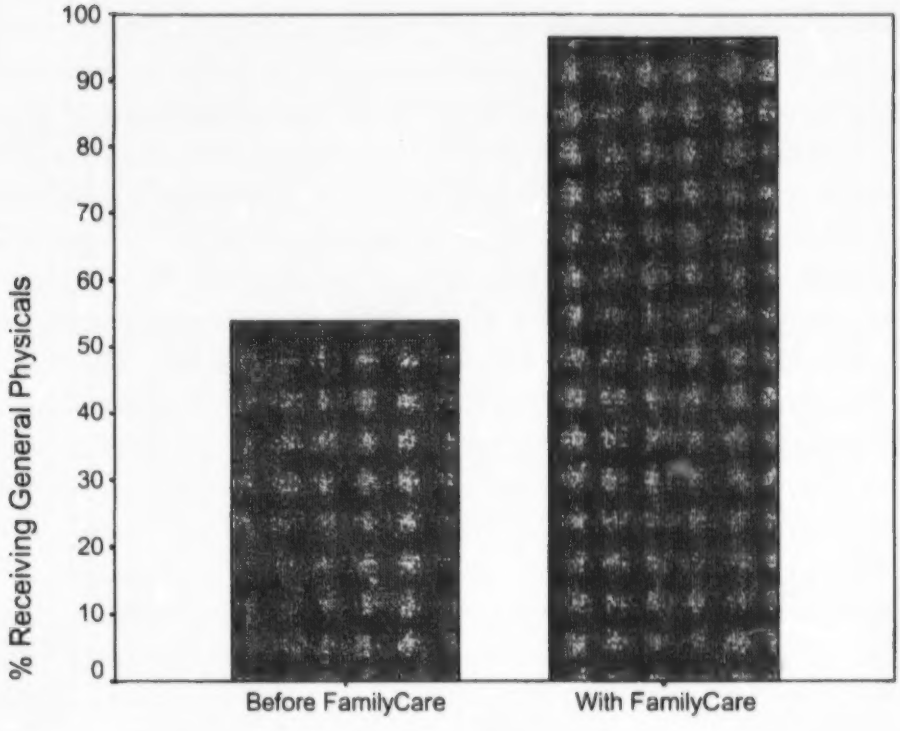
In our analyses, we compared the changes in the markers of healthcare and healthcare access before and after enrollment in the FamilyCare Program. Our results demonstrate that enrollment in FamilyCare significantly increases the likelihood that children will have a medical home, will receive preventative care and prompt access to healthcare when ill, and that financial barriers will be less likely to prevent children from receiving medication. In all areas we measured, then, FamilyCare was successful.

The Table below summarizes our findings; the pages that follow illustrate and discuss each finding.

INDICATORS OF CHILDREN'S HEALTHCARE ACCESS	BEFORE FAMILYCARE	WITH FAMILYCARE
Have primary care provider	61%	95%
All children see same doctor or group practice	58%	92%
Receive general physicals	53%	97%
Dental check-ups	21%	75%
Immunizations up to date	79%	97%
Access of doctor care immediately when needed	31%	73%
Parents always purchase prescribed medication	27%	92%

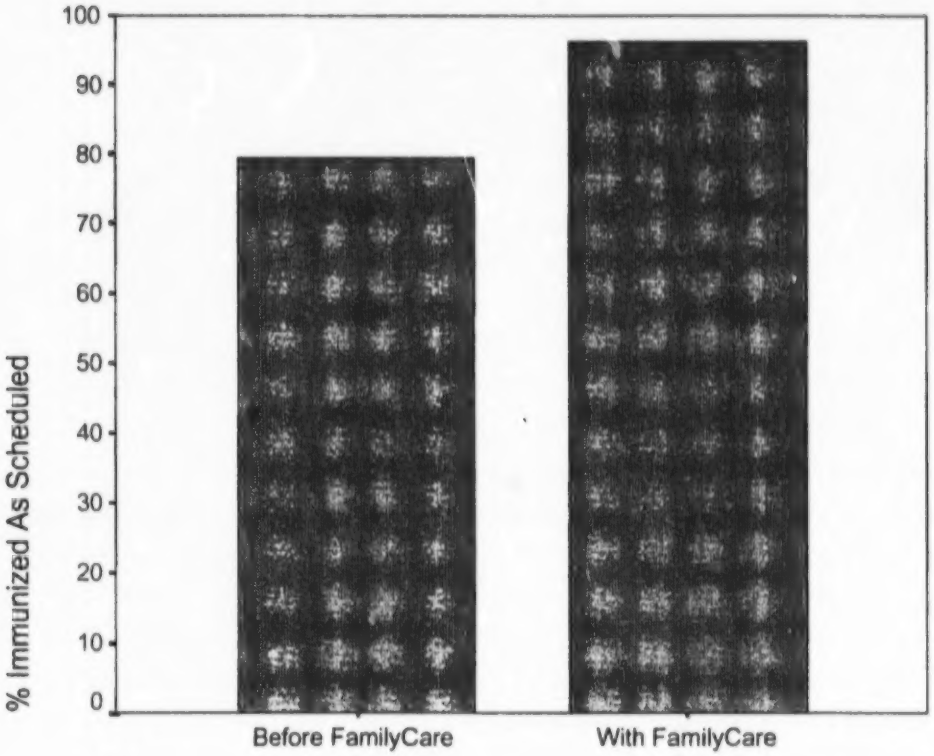


This graph shows the proportion of respondents who used the same primary care doctor or group of doctors for each of their children before and after enrollment. A medical home is very important for children in that it eliminates costly and inefficient fragmented care and aids in the detection of developmental problems. Before FamilyCare, 61% of parents reported that their children saw the same doctor; following enrollment, 95% said that their children now saw the same physician.

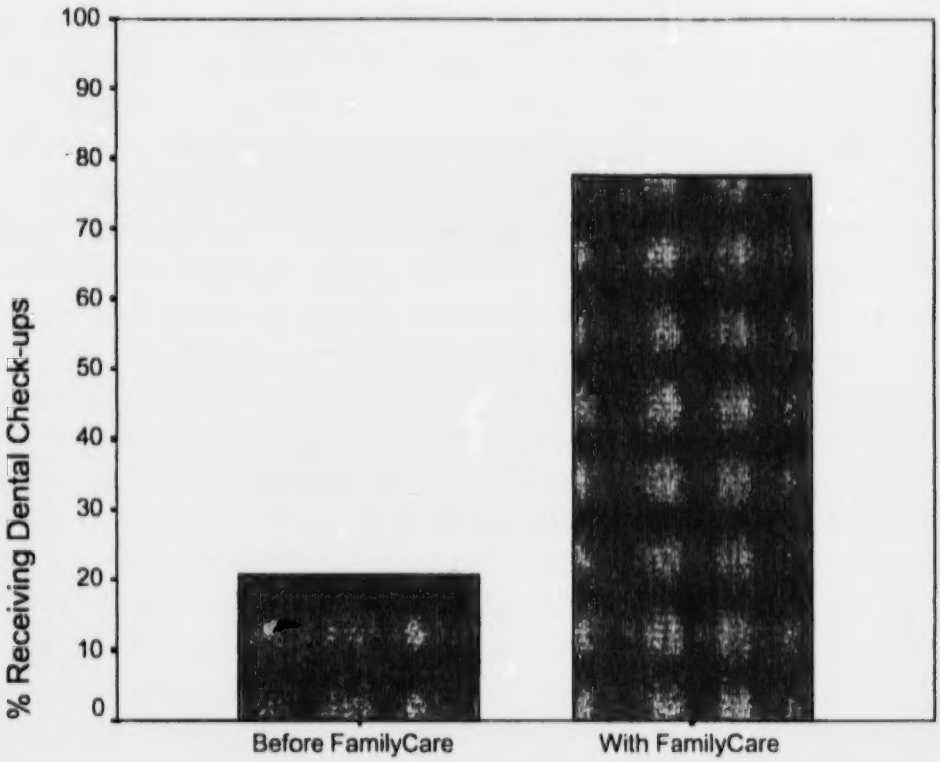


Regular well-child exams are extremely important for maintaining and promoting the health of children. Physical exams serve a number of functions including the early detection and prevention of developmental problems and illnesses, the administration of necessary immunizations and providing parents with the anticipatory guidance necessary to improve the health of their child.

This graph shows the percentage of respondents who received general physicals for their children before and after enrollment. Notice that the percentage of participants who received general physicals increased from 53% before enrollment to 97% after enrollment.



This graph shows the proportion of respondents whose children were up to date with their immunizations before and after enrollment in the FamilyCare program. Before enrollment 79% said their children were up to date with their immunizations and after enrollment 97% said their children were.



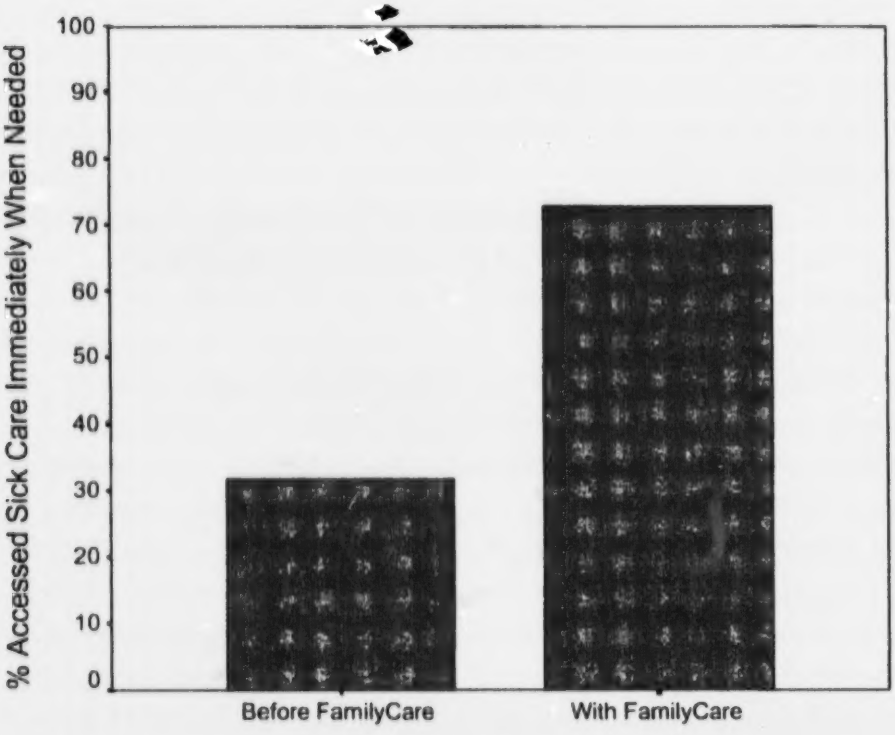
This graph shows the percentage of respondents who received dental check-ups before and after FamilyCare. Children who do not receive regular screenings and cleanings lose teeth and endure tooth pain for long periods of time. The percentage of participants who said they received dental check-ups before enrollment was 21%; 75% said they had received dental check-ups with FamilyCare.

Ninety-seven percent of respondents felt that having health insurance reduced their level of anxiety when their children were sick. Many reasoned that having health insurance meant that they could get to the doctor right away and get the necessary treatment for their child before they became worse. It also meant less guesswork about the cause of their child's illness and would eliminate the need to treat them with over the counter medications.

One mother told us that her son didn't report a health problem, because he knew that his family couldn't afford healthcare. This experience was obviously very stressful for the child and for the parent:

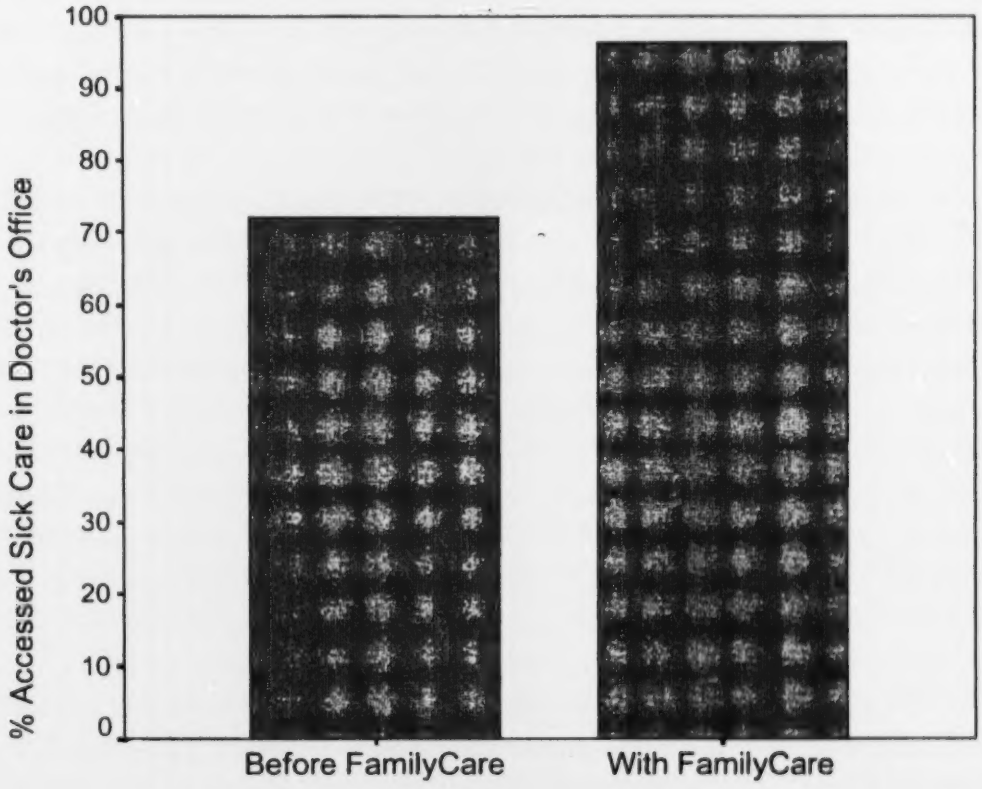
> *My son had a polyp. He had been bleeding for a year and never told us ...rectally bleeding and never told us. He said 'Mom, I am sure I have cancer'. When he finally told us he was almost in tears. And we were shocked and I said why did you wait a year to tell us...He said ' I was embarrassed and I thought it would go away...Cause it would stop and come back. Finally, he told us. I guess he finally figured it was really bad. We took him to the doctor and found out that he had a polyp. And it could be corrected. Only because of FamilyCare were we able to have that surgery. But, it was the fact that he waited so long knowing he didn't have coverage. This is a real success story as far as I am concerned."*

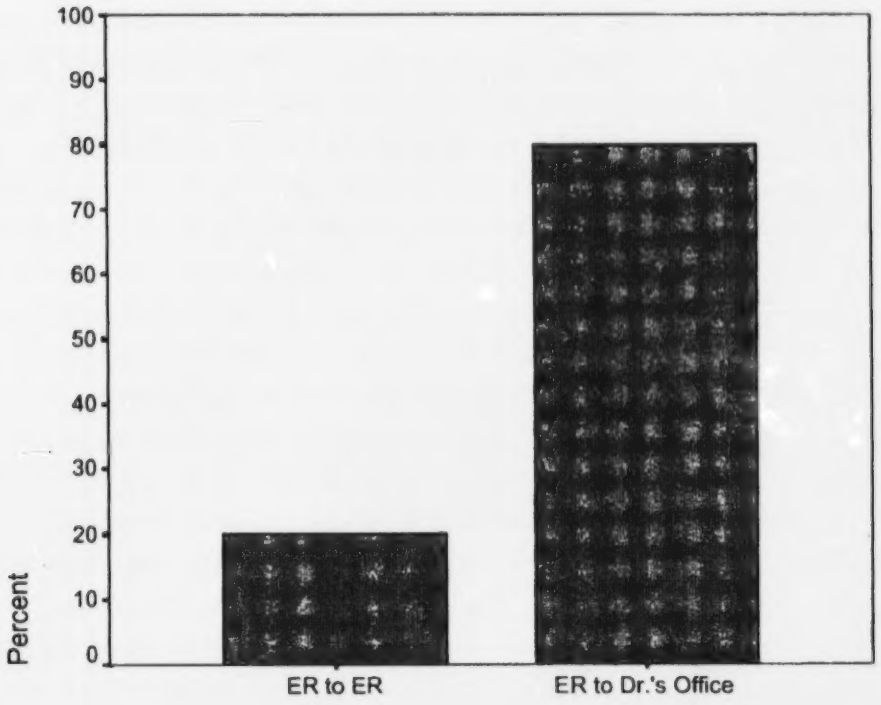
The graph on the next page illustrates the increase in immediate access to healthcare that followed from the acquisition of FamilyCare.



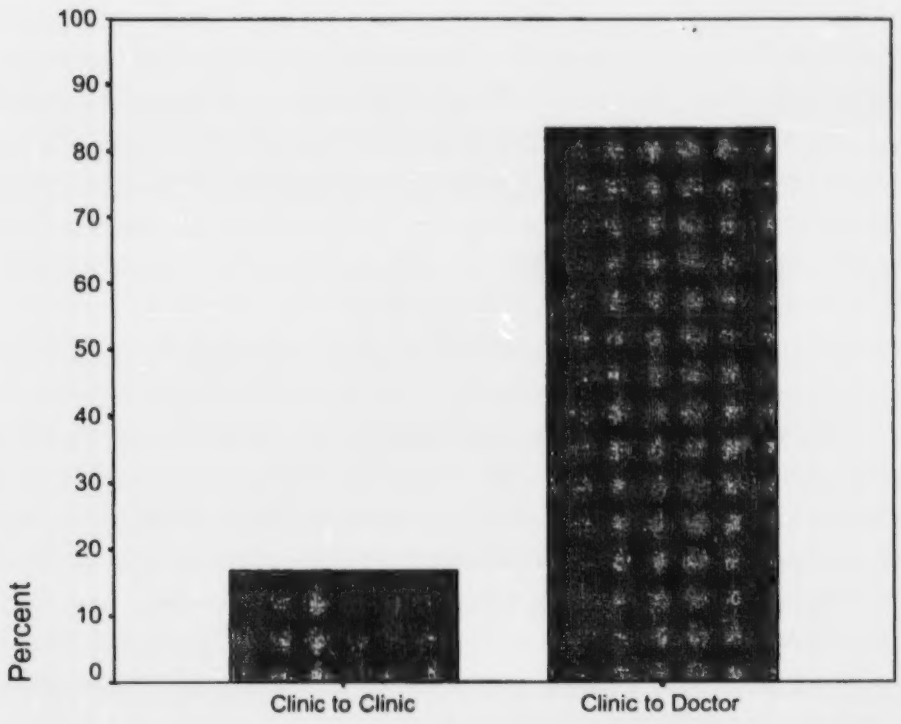
The cost of medical care can be so prohibitively high that parents without the means to pay for these necessary services will often forego doctor office visits, in the hope that their child will recover without the need for medical intervention. Inevitably, many of these untreated children will end up seeking more costly care in the emergency room. Many others will just suffer and endure. As the graph indicates, those with insurance are more apt to access the needed care immediately than to wait. The number of participants who accessed care immediately when it was needed increased from 31% before FamilyCare to 73% after enrollment.

Before enrollment in the NJKC program 72% reported using a doctor's office or group practice when their children were sick. This increased to 96% after their enrollment. Of the 28% who did not use a doctor's office before enrollment, 11 % accessed care in a community clinic and 17 % accessed care in the emergency room. These numbers dropped to 3% and 1% respectively after enrollment. Many who accessed care in the emergency room stated that it was the inability to pay immediately that prevented them from going to the doctor's office. They relied on the ER because they would be billed later. Others stated that by relying on the ER they did not have to miss work in order to seek care for their children.

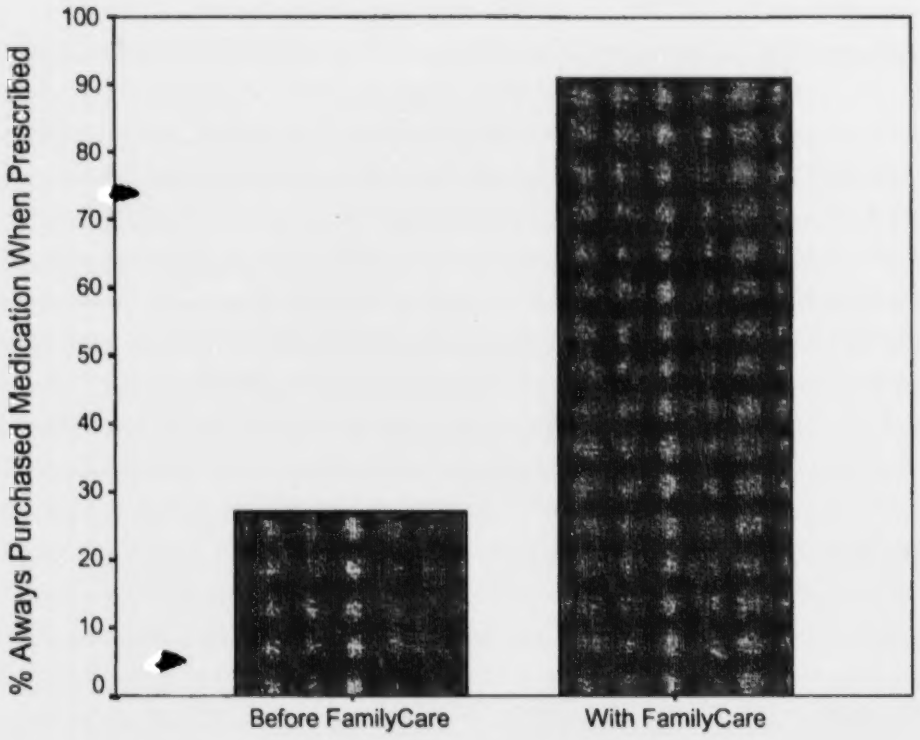




This graph shows where the respondents who had accessed care in the emergency room prior to their enrollment accessed care after their enrollment. After enrollment 20% continued to access care in the emergency room and 80% accessed care in a doctor's office. In other words, parents who relied on the emergency room for care for their children switched to visiting doctors' offices once they obtained health insurance.



This graph shows where the respondents who had accessed care in a community clinic prior to their enrollment accessed care after their enrollment. After enrollment 17% continued to access care in the community clinic and 83% sought care in a doctor's office.



This graph shows the percentage of respondents who always purchased prescribed medication for their children. Before enrollment 27% always purchased the medication and 92% did so after enrollment. The reason many cited for not purchasing prescribed medication was cost. Many of the respondents said they would ask the doctors for samples so that they could give their children the medication that was needed.

The inability to purchase prescribed medications resulted in parents to triage medical problems, and decide that a child's illness would go untreated. One mother told us:

> *"Sometimes, like my kids have asthma and they had that...but like for an ear infection...like amoxicillan...I would ask the doctors, 'Can he go without that?' And she would say, 'Yeah! It will heal on its own. It will hurt but the ear infection will go away on its own without the amoxicillan'."*

This kind of experience is obviously very stressful and upsetting to parents.

Overview of Other Findings

We also asked mothers a number of other questions in our interviews. The results of the survey suggest that having health insurance improved consumers' perceptions that they were receiving high quality health care. Sixty-eight percent of the mothers reported that there was an improvement in the quality of care their families received once they obtained health insurance. Many mothers stated that prior to enrollment in FamilyCare, they sometimes were not seen by a provider, they had to wait longer amounts of time for appointments, they had to endure demeaning attitudes of doctors and staff, and felt that they were given cheaper, less effective medications. They also believed the number of diagnostic tests performed on those without insurance was smaller than the number performed on insured children. It is no surprise then that 71% of the mothers we interviewed believe that their children are healthier with medical insurance than they were without it.

Parental perceptions of control increased across four measures. These measures included:

- parental anxiety level when child was sick,
- comfort level in taking child to doctor,
- worry about future illnesses,
- parental effectiveness concerning management of child's healthcare.

Of those parents who felt anxious when their children were sick, 97% reported that having health insurance reduced their anxiety greatly. For those who worried about their children becoming sick, 96% believed that health insurance eliminated some of their worries. Ninety-five percent of the parents stated that they felt more comfortable taking their children to the doctor with health insurance and 97% felt that health insurance allowed them to be more effective in managing their child's healthcare.

Conclusion

The results of this study demonstrate that the provision of health insurance improves healthcare access for the low-income population. The New Jersey FamilyCare Program is a success.

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